



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

LIBERTY INSURANCE CORPORATION
8705 KATY FWY STE 105
HOUSTON TX 77024-1708

Respondent Name

Ihsan Shanti, MD, and
Shanti Pain & Wellness Center

Carrier's Austin Representative Box

Box Number 1

MFDR Tracking Number

M4-10-1975-01

MFDR Date Received

November 30, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Liberty recognizes and acknowledges that this request is not filed within one year from the dates of service in question, as required by former Division Rule 133.307(d)(2). Liberty asserts that this provision is inapplicable to this dispute as the Provider billed for services which it did not perform and deliberately coded and documented the bills to conceal its improper actions."

Amount in Dispute: \$16,197.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Shanti prays that the Division dismiss Liberty's untimely and unfounded request as required pursuant to Former Division Rule 133.307(d)(2)."

Response Submitted by: Shepherd, Scott, Clawwater & Houston, 2777 Allen Parkway, 7th Floor, Houston, Texas 77019

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 19, 2005 to December 12, 2005	Insurance Carrier Refund Request	\$16,197.61	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

Issues

1. What version of 28 Texas Administrative Code §133.307 applies to this request for medical fee dispute resolution?
2. May the insurance carrier request medical fee dispute resolution?
3. Did the insurance carrier timely file the request for medical fee dispute resolution?

Findings

1. Former 28 Texas Administrative Code §133.307(a)(1), effective May 25, 2008, 33 *Texas Register* 3954, states that "This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care not subject to a contract, that is remanded to the Division or filed on or after May 25, 2008." This request for medical fee dispute resolution was received by the Division on November 30, 2009. The Division therefore concludes that this version of §133.307 is the applicable rule for review of the issues in this dispute.
2. §133.307(b) states that "The following parties may be requestors in medical fee disputes: (1) the health care provider (provider), or a qualified pharmacy processing agent, as described in Labor Code §413.0111, in a dispute over the reimbursement of a medical bill(s); (2) the provider in a dispute about the results of a Division or carrier audit or review which requires the provider to refund an amount for health care services previously paid by the insurance carrier; (3) the injured employee (employee) in a dispute involving an employee's request for reimbursement from the carrier of medical expenses paid by the employee; or (4) the employee when requesting a refund of the amount the employee paid to the provider in excess of a Division fee guideline." The insurance carrier is not listed as a party that may request medical fee dispute resolution. The Division therefore concludes that the insurance carrier is not entitled to request medical fee dispute resolution of the issues in this dispute.
3. §133.307(c)(1) states that "A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the services in dispute are from April 19, 2005 to December 12, 2005. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on November 30, 2008. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the insurance carrier is not entitled to request medical fee dispute resolution. For that reason, the merits of the fee issues raised by either party to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the insurance carrier is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>December 5, 2013</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.